		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039826

Facility Name: Mount Vernon Care Center

Address: 1717 Jefferson Street (Number) Mount Vernon (City) 62864 (Zip Code)

County: Jefferson

Telephone Number: (618) 244-2861 **Fax #** (618) 244-7677

IDPA ID Number: 391516877002

Date of Initial License for Current Owners: 10/01/94

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 06/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser, LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	64	Intermediate (ICF)	64	23,360	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	64	TOTALS	64	23,360	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	16,931	3,425		20,356	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,931	3,425		20,356	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.14%

D. How many bed-hold days during this year were paid by Public Aid? 27 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/02 Fiscal Year: 06/30/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	75,373	7,691	3,881	86,945		86,945		86,945			1
2	Food Purchase		78,270		78,270		78,270	(11,049)	67,221			2
3	Housekeeping	53,595	5,671		59,266		59,266		59,266			3
4	Laundry	35,012	6,987		41,999		41,999		41,999			4
5	Heat and Other Utilities			35,433	35,433		35,433		35,433			5
6	Maintenance	18,402		14,740	33,142		33,142		33,142			6
7	Other (specify):*											7
8	**TOTAL General Services**	182,382	98,619	54,054	335,055		335,055	(11,049)	324,006			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	553,777	22,977	741	577,495		577,495		577,495			10
10a	Therapy			367	367		367		367			10a
11	Activities	25,074	1,780	1,306	28,160		28,160		28,160			11
12	Social Services	17,743	38	922	18,703		18,703		18,703			12
13	Nurse Aide Training											13
14	Program Transportation			403	403		403		403			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	596,594	24,795	9,739	631,128		631,128		631,128			16
	C. General Administration											
17	Administrative	39,833		210,300	250,133		250,133		250,133			17
18	Directors Fees							9,151	9,151			18
19	Professional Services			866	866		866	29,918	30,784			19
20	Dues, Fees, Subscriptions & Promotions			5,844	5,844		5,844	64	5,908			20
21	Clerical & General Office Expenses	18,501	4,134	18,576	41,211		41,211	(1,583)	39,628			21
22	Employee Benefits & Payroll Taxes			104,903	104,903		104,903	54,279	159,182			22
23	Inservice Training & Education			22	22		22		22			23
24	Travel and Seminar			2,562	2,562		2,562	1,262	3,824			24
25	Other Admin. Staff Transportation			407	407		407	1,012	1,419			25
26	Insurance-Prop.Liab.Malpractice							38,109	38,109			26
27	Other (specify):*											27
28	**TOTAL General Administration**	58,334	4,134	343,480	405,948		405,948	132,212	538,160			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	837,310	127,548	407,273	1,372,131		1,372,131	121,163	1,493,294			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mount Vernon Care Center #0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			6,514	6,514		6,514	64,133	70,647			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,502	3,502		3,502	170,916	174,418			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			256,545	256,545		256,545	(256,545)				34
35	Rent-Equipment & Vehicles			2,924	2,924		2,924	42	2,966			35
36	Other (specify):* **MIP Insurance**							9,773	9,773			36
37	**TOTAL Ownership**			269,485	269,485		269,485	(11,681)	257,804			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							1,777	1,777			39
40	Barber and Beauty Shops			8	8		8		8			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,040	35,040		35,040		35,040			42
43	Other (specify):* **Nonallowable Costs**			9,792	9,792		9,792	(9,792)				43
44	**TOTAL Special Cost Centers**			44,840	44,840		44,840	(8,015)	36,825			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	837,310	127,548	721,598	1,686,456		1,686,456	101,467	1,787,923			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(249)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,446	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(2,958)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,542)	43		18
19	Entertainment				19
20	Contributions	(52)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(718)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,299)	43		28
29	Other-Attach Schedule See Schedule 5A	(3,760)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (13,132)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	114,599		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 114,599		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 101,467		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Mount Vernon Care Center

ID# 0039826

Report Period Beginning: 07/01/01

Ending: 06/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Mount Vernon Care Center
Provider # 0039826
June 30, 2002

Schedule 5A

Schedule VI. Part A - Adjustment Detail, Line 29

Non-allowable expenses	Amount	Reference
Miscellaneous income offset	(3,539)	21
Non-allowable Chamber of Commerce dues	(221)	20
Total	(3,760)	

See Accountants' Compilation Report

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mount Vernon Care Center **#** 0039826 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	3,813	5,338	0	0	0	0	0	0	0	0	9,151	18
19	Professional Services	0	9,419	12,643	7,856	0	0	0	0	0	0	0	29,918	19
20	Fees, Subscriptions & Promotions	0	61	91	133	0	0	0	0	0	0	0	285	20
21	Clerical & General Office Expenses	0	484	1,447	25	0	0	0	0	0	0	0	1,956	21
22	Employee Benefits & Payroll Taxes	0	0	43,230	0	0	0	0	0	0	0	0	43,230	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	250	1,012	0	0	0	0	0	0	0	0	1,262	24
25	Other Admin. Staff Transportation	0	1,012	0	0	0	0	0	0	0	0	0	1,012	25
26	Insurance-Prop.Liab.Malpractice	0	152	100	37,857	0	0	0	0	0	0	0	38,109	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	15,191	63,861	45,871	0	0	0	0	0	0	0	124,923	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	15,191	63,861	45,871	0	0	0	0	0	0	0	124,923	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mount Vernon Care Center # 0039826 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,446	1,036	0	59,651	0	0	0	0	0	0	0	64,133	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,958)	1,154	892	171,828	0	0	0	0	0	0	0	170,916	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	(256,545)	0	0	0	0	0	0	0	(256,545)	34
35	Rent-Equipment & Vehicles	0	42	0	0	0	0	0	0	0	0	0	42	35
36	Other (specify):*	0	0	0	9,773	0	0	0	0	0	0	0	9,773	36
37	TOTAL Ownership	488	2,232	892	(15,293)	0	0	0	0	0	0	0	(11,681)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	1,777	0	0	0	0	0	0	0	0	0	1,777	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(9,860)	0	0	68	0	0	0	0	0	0	0	(9,792)	43
44	TOTAL Special Cost Centers	(9,860)	1,777	0	68	0	0	0	0	0	0	0	(8,015)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(9,372)	19,200	64,753	30,646	0	0	0	0	0	0	0	105,227	45

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Caravilla Resident Centers, Inc. -	100.00%	See attached Related Party Schedule		See attached Related Party Schedule		
See attached Schedule 7A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	Board fees	$	Center for Residential Management, Inc.	**	$ 3,813	$ 3,813	1
2	V	19	Professional fees		Center for Residential Management, Inc.	**	9,419	9,419	2
3	V	20	Licenses, dues, & subs		Center for Residential Management, Inc.	**	61	61	3
4	V	21	Office supplies & telephone		Center for Residential Management, Inc.	**	484	484	4
5	V	24	Travel & seminar		Center for Residential Management, Inc.	**	250	250	5
6	V	25	Vehicle expense		Center for Residential Management, Inc.	**	1,012	1,012	6
7	V	26	Vehicle, fire & liab insurance		Center for Residential Management, Inc.	**	152	152	7
8	V	30	Depreciation		Center for Residential Management, Inc.	**	1,036	1,036	8
9	V	32	Interest expense		Center for Residential Management, Inc.	**	1,154	1,154	9
10	V	35	Vehicle lease		Center for Residential Management, Inc.	**	42	42	10
11	V	39	Ancillary service centers		Center for Residential Management, Inc.	**	1,777	1,777	11
12	V								12
13	V								13
14	Total			$			$ 19,200	$ * 19,200	14

** Center for Residential Management, Inc. is Caravilla Resident Centers, Inc.'s parent company.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule VII - Related Parties **Related Party Schedule**
Page 6, Section A, Column 2, Related Nursing Homes

Name	Facility Name	City
Progressive Housing, Inc.	Gateway Terrace	Irvington
	Aviston Terrace	Aviston
	Briarbrook Place	East Peoria
	Joshua Manor	Hoyleton
	Terra Estates	Hoyleton
	Park Place	Pana
	Harris Place	East Peoria
	Okawville	Okawville
	Billy Goat Hill	Mt. Vernon
	Country Club Hills (185th St.)	Country Club Hills
	Country Club Hills (Lee St.)	Country Club Hills
	Galaxy	Woodlawn
	Perrine	Centralia
	Troy	Troy
	Western Gardens	Mt. Vernon
	Cardinal	Woodlawn
Residential Centers, Inc.	Lakeview Living Center	Chicago
	Countryview Living Center	Latham
	Sparta Terrace	Sparta
	Taylorville Terrace	Taylorville
	Ellner Terrace	Evansville
Caravilla Resident Centers, Inc.	Mt. Vernon Care Center	Mt. Vernon
	Jeffersonian Care Center	Mt. Vernon
	Casey Care Center	Mt. Vernon

Schedule VII, Related Parties
Page 6, Section A, Column 3, Other Related Business Entities

Name	City	Type of Business
Center for Residential Management, Inc.	Peoria	Management/Holding Co.
Residential Centers, Inc.	Peoria	ICF/DD Provider
Progressive Housing, Inc.	Peoria	ICF/DD Provider
Caravilla Charitable Corporation	Mt. Vernon	Lessor
Caravilla Resident Centers, Inc.	Mt. Vernon	SNF/ICF Provider

See Accountants' Compilation Report

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	18	Board fees	$	Caravilla Resident Centers, Inc.	100.00%	$ 5,338	$ 5,338	15
16	V	19	Professional fees		Caravilla Resident Centers, Inc.	100.00%	12,643	12,643	16
17	V	20	Licenses, dues & subscriptions		Caravilla Resident Centers, Inc.	100.00%	91	91	17
18	V	21	Office supplies & telephone		Caravilla Resident Centers, Inc.	100.00%	1,447	1,447	18
19	V	22	Emp. benefits & payroll taxes		Caravilla Resident Centers, Inc.	100.00%	43,230	43,230	19
20	V	24	Travel & seminar		Caravilla Resident Centers, Inc.	100.00%	1,012	1,012	20
21	V	26	Vehicle, fire & liab. insurance		Caravilla Resident Centers, Inc.	100.00%	100	100	21
22	V	32	Interest expense		Caravilla Resident Centers, Inc.	100.00%	892	892	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 64,753	$ * 64,753	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$	Caravilla Charitable Corporation	**	$ 7,856	$ 7,856	15
16	V	20	Licenses, dues & subscriptions		Caravilla Charitable Corporation	**	133	133	16
17	V	21	Office supplies & telephone		Caravilla Charitable Corporation	**	25	25	17
18	V	26	Vehicle, fire & liab. insurance		Caravilla Charitable Corporation	**	37,857	37,857	18
19	V	30	Depreciation		Caravilla Charitable Corporation	**	59,651	59,651	19
20	V	32	Interest expense		Caravilla Charitable Corporation	**	171,828	171,828	20
21	V	34	Rent expense	256,545	Caravilla Charitable Corporation	**		(256,545)	21
22	V	36	MIP insurance		Caravilla Charitable Corporation	**	9,773	9,773	22
23	V	43	Penalties			**	68	68	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V				**Caravilla Charitable Corporation and Caravilla				28
29	V				Resident Centers, Inc. have the same parent company.				29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 256,545			$ 287,191	$ * 30,646	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Robert Bauer	President	Board Member	None	12,390	2 hrs mtg.		Directors Fees	$ 1,610	L18,C8	1
2	Roger Ryan	Vice President	Board Member	None	2,326	2 hrs mtg.		Directors Fees	874	L18,C8	2
3	William Armstrong	Treasurer	Board Member	None	2,326	2 hrs mtg.		Directors Fees	874	L18,C8	3
4	Kay Baker	Secretary	Board Member	None	2,326	2 hrs mtg.		Directors Fees	874	L18,C8	4
5	Ronald O'Daniell	Director	Board Member	None	2,326	2 hrs mtg.		Directors Fees	874	L18,C8	5
6	Merla McCloud	Recorder	Administrative	None	16,899	2 hrs mtg.		Directors Fees	1,501	L18,C8	6
7	Ron Schroeder	Board Member	Board Member	None	14,770	2 hrs mtg.		Directors Fees	630	L18,C8	7
8	Darrell Boehne	Board Member	Board Member	None	14,770	2 hrs mtg.		Directors Fees	630	L18,C8	8
9	Edward Childers	Board Member	Board Member	None	14,546	2 hrs mtg.		Directors Fees	654	L18,C8	9
10	Orland Bauer	Board Member	Board Member	None	9,770	2 hrs mtg.		Directors Fees	630	L18,C8	10
11											11
12											12
13								TOTAL	$ 9,151		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SCHEDULE 7A

Board of Directors Fees

	Ron Schroeder	Darrell Boehne	Edward Childers	Bob Bauer	Cora Flota	Orland Bauer	Kay Schuman Johnson	Roger Ryan	Ronald O'Daniell	William Armstrong	Kay Baker	Merla McCloud	Totals
Residential Centers, Inc.													
Lakeview Living Center	3,757	3,606	3,606	3,606								3,606	18,181
Sparta Terrace	415	398	398	398								398	2,006
Ellner Terrace	415	398	398	398								398	2,006
Taylorville Terrace	415	398	398	398								398	2,006
Total RCI	5,000	4,800	4,800	4,800	0	0	0	0	0	0	0	4,800	24,200
Progressive Housing, Inc.													
Aviston Terrace	553	576	553		553	553	282					553	3,623
Harris Place	553	576	553		553	553	282					553	3,623
Briarbrook Place	553	576	553		553	553	282					553	3,623
Joshua Manor	553	576	553		553	553	282					553	3,623
Terra Estates	553	576	553		553	553	282					553	3,623
Park Place	553	576	553		553	553	282					553	3,623
Okawville	207	216	207		207	207	106					207	1,358
Perrine	138	144	138		138	138	71					138	906
Western Gardens	138	144	138		138	138	71					138	905
Galaxy	276	288	276		276	276	141					276	1,811
Billy Goat Hill	276	288	276		276	276	141					276	1,811
Troy	138	144	138		138	138	71					138	906
Country Club Hills - 185th St.	207	216	207		207	207	106					207	1,357
Country Club Hills - Lee St.	101	101	101		101	101	0					101	608
Total PHI	4,800	5,000	4,800	0	4,800	4,800	2,400	0	0	0	0	4,800	31,400
Caravilla Resident Centers, Inc.													
Mt. Vernon				980				871	871	871	871	871	5,338
Jeffersonian Care Center				996				885	885	885	885	885	5,421
Casey Care Center				1,624				1,443	1,443	1,443	1,443	1,443	8,841
Total CRC	0	0	0	3,600	0	0	0	3,200	3,200	3,200	3,200	3,200	19,600
Center for Residential Management, Inc. *	5,600	5,600	5,600	5,600		5,600						5,600	33,600
Total Board of Directors Fees	15,400	15,400	15,200	14,000	4,800	10,400	2,400	3,200	3,200	3,200	3,200	18,400	108,800

* Center for Residential Management, Inc.'s board fees are allocated to each facility.

Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business transactions with the nursing home during the reporting period.

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Center for Residential Management, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional fees	Bed days available	207,498	21	$ 7,680	$	23,360	$ 865	1
2	20	Licenses, dues, & subs	Bed days available	207,498	21	(100)		23,360	(11)	2
3	21	Office supplies & telephone	Bed days available	207,498	21	(861)		23,360	(97)	3
4	24	Travel & seminar	Bed days available	207,498	21	(580)		23,360	(66)	4
5	25	Vehicle expense	Bed days available	207,498	21	8,145		23,360	917	5
6	26	Vehicle, fire & liab. insurance	Bed days available	207,498	21	1,353		23,360	152	6
7	30	Depreciation	Bed days available	207,498	21	9,194		23,360	1,036	7
8	32	Interest expense	Bed days available	207,498	21	8,154		23,360	918	8
9	35	Vehicle lease	Bed days available	207,498	21	375		23,360	42	9
10	39	Ancillary service centers	Bed days available	207,498	21	15,783		23,360	1,777	10
11										11
12										12
13										13
14	18	Board fees	Direct method						3,813	14
15	19	Professional fees	Direct method						8,554	15
16	20	Licenses, dues, & subs	Direct method						72	16
17	21	Office supplies & telephone	Direct method						581	17
18	24	Travel & seminar	Direct method						316	18
19	25	Vehicle expense	Direct method						95	19
20	32	Interest expense	Direct method						236	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 49,143	$		$ 19,200	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Caravilla Resident Centers, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	Board fees	Number of beds	235	3	$ 19,600	$	64	$ 5,338	1
2	19	Professional fees	Number of beds	235	3	46,424		64	12,643	2
3	20	Licenses, dues & subscriptions	Number of beds	235	3	335		64	91	3
4	21	Office supplies & telephone	Number of beds	235	3	5,308		64	1,447	4
5	22	Emp. benefits & payroll taxes	Number of beds	235	3	(567)		64	(135)	5
6	24	Travel & seminar	Number of beds	235	3	3,716		64	1,012	6
7	32	Interest expense	Number of beds	235	3	892		64	892	7
8										8
9										9
10	22	Emp. benefits & payroll taxes	Direct method						43,365	10
11	26	Vehicle, fire & liab. insurance	Direct method						100	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 75,708	$		$ 64,753	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Continental Wingate		x	Purchase facility	$55,560.00	09/01/96	$ 7,402,500	$ 1,947,943	10/01/31	0.0855	$ 167,222	1
2	NCS Healthcare, Inc.		x	Hardware/Software	$689.00	10/31/98	27,579	10,577	09/30/03	0.1429	954	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$56,249.00		$ 7,430,079	$ 1,958,520			$ 168,176	9
	B. Non-Facility Related*											
10						Miscellaneous interest					5,776	10
11						Nonallowable interest expense and interest income offset					(3,949)	11
12						Amortization expense					3,497	12
13						Parent company allocation					918	13
14	TOTAL Non-Facility Related						$	$			$ 6,242	14
15	TOTALS (line 9+line14)						$ 7,430,079	$ 1,958,520			$ 174,418	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 9,773 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mount Vernon Care Center COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0039826

CONTACT PERSON REGARDING THIS REPORT Rob Keime

TELEPHONE (309) 685-0595 FAX #: (309) 685-8463

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.	N/A		$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,500 B. General Construction Type: Exterior Brick Frame Block Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	81,300	1994	$ 60,000	1
2					2
3	TOTALS	81,300		$ 60,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1994	1994	$ 1,229,600	$	40	$ 30,740	$ 30,740	$ 238,235	4
5			1998	1998	5,394		40	135	135	607	5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvements			1995	3,187		15	212	212	1,551	9
10	Architectural services			1996	4,794		15	320	320	1,720	10
11	Architectural services			1997	1,198		15	80	80	430	11
12	Air compressor			1996	1,230		15	82	82	441	12
13	Electrical			1996	1,710		15	114	114	613	13
14	Exit lighting			1997	1,354		15	90	90	484	14
15	Blinds, wallpaper & paint			1997	3,329		15	222	222	1,189	15
16	Waterproof basement			1997	7,822		15	521	521	2,801	16
17	Windows & doors			1997	2,878		15	192	192	1,032	17
18	Plastering			1997	20,386		15	1,359	1,359	7,305	18
19	Flooring			1997	4,544		15	303	303	1,363	19
20	Gutters			1997	8,933		15	596	596	2,682	20
21	Shutters & windows			1997	1,882		15	125	125	563	21
22	Remodeling of facility			1997	4,153		15	277	277	1,246	22
23	Plumbing			1997	15,420		15	1,028	1,028	4,626	23
24	Electrical service			1997	32,765		15	2,184	2,184	9,828	24
25	Paint & wallpaper			1997	8,366		15	558	558	2,511	25
26	Sidewalk			1997	780		15	52	52	234	26
27	Electrical service			1998	1,340		15	89	89	401	27
28	Flooring			1998	27,771		15	1,851	1,851	8,330	28
29	Remodeling of facility			1998	154		15	10	10	45	29
30	Paint & wallpaper			1998	262		15	17	17	77	30
31	Landscaping			1998	7,964		15	531	531	2,389	31
32	Windows			1998	1,599		15	107	107	481	32
33	Air conditioner			1998	578		15	39	39	176	33
34	Landscaping			1999	1,699		15	113	113	396	34
35	Cabinets			1999	1,220		15	81	81	284	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Renovation of nurse station	1999	$ 6,059	$	15	$ 404	$ 404	$ 1,414	37
38	Security System	1999	1,245		15	83	83	291	38
39	Water heater	1999	1,990	132	15	132		330	39
40	Remodel resident rooms	1999	3,343		15	222	222	555	40
41	Remodel resident rooms	1999	3,477		15	232	232	580	41
42	Remodel common room	1999	942		15	62	62	155	42
43	Remodel common room	1999	3,212		15	214	214	535	43
44	Trim	1999	671		15	44	44	110	44
45	Door	2000	984	66	15	66		165	45
46	Concrete Floor Pad	2000	1,500	100	15	100		150	46
47	Air Compressor	2001	1,803	120	15	120		180	47
48	Labor for building improvements	2000	13,971		15	931	931	1,862	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,441,509	$ 418		$ 44,638	$ 44,220	$ 298,367	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 229,278	$ 4,816	$ 24,533	$ 19,717	5-10 years	$ 144,738	71
72	Current Year Purchases	918	46	46		10 years	46	72
73	Fully Depreciated Assets							73
74	Parent company allocation			1,036	1,036			74
75	TOTALS	$ 230,196	$ 4,862	$ 25,615	$ 20,753		$ 144,784	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	1997 Ford E150***	1997	$ 13,040	$	$	$	3	$ 13,040	76
77	Resident Transportation	1998 Chevy Corsica***	2002	489	81	81		3	81	77
78	Resident Transportation	1997 Ford Taurus***	2002	978	163	163		3	163	78
79	Resident Transportation	1992 Chevy Van***	2002	900	150	150		3	150	79
80	TOTALS			$ 15,407	$ 394	$ 394	$		$ 13,434	80

*** Cost allocated between 3 facilities

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,747,112	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 5,674	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 70,647	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 64,973	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 456,585	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [x] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [x] YES [ ] NO

16. Rental Amount for movable equipment: $ 1,399 Description: Dishwasher $1,300; Water Cooler $96; Ecolab $3
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Care	1995 Chevy Corsica	$ 83.00	$ 500	17
18	Resident Care	1997 Ford Taurus	108.00	650	18
19	Resident Care	1992 Chevy Van	63.00	375	19
20	Parent company allocation			42	20
21	TOTAL		$ 254.00	$ 1,567	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		4	63		4	63	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Part B MCR supplies	L39, C8					1,777		1,777	13
14	TOTAL			$	4	$ 63	$ 1,777	4	$ 1,840	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 89,965	$ 89,965	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 7,614)	223,074	223,074	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,479	5,479	6
7	Other Prepaid Expenses	192	192	7
8	Accounts Receivable (owners or related parties)	319,229	319,229	8
9	Other(specify): Deposit	1,376	1,376	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 639,315	$ 639,315	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		60,000	13
14	Buildings, at Historical Cost		1,234,994	14
15	Leasehold Improvements, at Historical Cost	6,276	206,515	15
16	Equipment, at Historical Cost	34,773	245,603	16
17	Accumulated Depreciation (book methods)	(16,972)	(456,585)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Investment in Sub.	1,500	1,500	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 25,577	$ 1,292,027	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 664,892	$ 1,931,342	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 97,134	$ 97,134	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	6,536	6,536	29
30	Accrued Salaries Payable	50,347	50,347	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	465,802	113,053	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 619,819	$ 267,070	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,041	1,951,984	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,041	$ 1,951,984	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 623,860	$ 2,219,054	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 41,032	$ (287,712)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 664,892	$ 1,931,342	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Mount Vernon Care Center
Provider # 0039826
June 30, 2002

Schedule 17A

XV. Balance Sheet

	Operating	After Consolidation
Line 36 - Other		
Accrued Expense	4,758	4,758
Accrued Rent	352,749	-
Accrued Participation Fees	8,736	8,736
Resident Credit Balances	56,673	56,673
Prepaid Respro	42,886	42,886
Total	465,802	113,053

See Accountants' Compilation Report

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 188,001	1
2	Restatements (describe):		2
3	**Prior period adjustment**	(5,090)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 182,911	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(63,459)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Parent company allocation**	(78,420)	15
16	Other (describe) **added back in column 7**		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (141,879)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 41,032	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,615,084	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,615,084	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	678	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 678	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	450	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,745	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,195	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	81	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 81	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous Income**	3,959	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,959	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,622,997	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	335,055	31
32	Health Care	631,128	32
33	General Administration	405,948	33
	B. Capital Expense		
34	Ownership	269,485	34
	C. Ancillary Expense		
35	Special Cost Centers	9,800	35
36	Provider Participation Fee	35,040	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,686,456	40
41	**Income before Income Taxes (line 30 minus line 40)****	(63,459)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (63,459)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
A federal tax return is filed for the combined divisions of Caravilla Resident Centers, Inc.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,853	1,983	$ 33,309	$ 16.80	1
2	Assistant Director of Nursing	1,315	1,439	22,300	15.50	2
3	Registered Nurses	3,102	3,262	50,618	15.52	3
4	Licensed Practical Nurses	9,834	10,534	137,199	13.02	4
5	Nurse Aides & Orderlies	33,964	36,301	273,223	7.53	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,588	2,808	22,463	8.00	8
9	Activity Director					9
10	Activity Assistants	3,515	3,750	25,074	6.69	10
11	Social Service Workers	2,022	2,190	17,743	8.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,138	11,753	75,373	6.41	15
16	Dishwashers					16
17	Maintenance Workers	1,924	2,046	18,402	8.99	17
18	Housekeepers	7,526	8,238	53,595	6.51	18
19	Laundry	5,113	5,530	35,012	6.33	19
20	Administrator	1,874	2,042	39,833	19.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,964	2,076	18,501	8.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	253	253	1,762	6.96	31
32	Other Health Ca See Sch 20A	1,042	1,067	12,903	12.09	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	89,027	95,272	$ 837,310 *	$ 8.79	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	89	$ 3,881	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	646	L10, C3	38
39	Pharmacist Consultant	Monthly	95	L10, C3	39
40	Physical Therapy Consultant	9	272	L10a, C3	40
41	Occupational Therapy Consultant	1	32	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	17	922	L11, C3	44
45	Social Service Consultant	17	922	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	133	$ 12,770		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Mount Vernon Care Center
Provider # 0039826
June 30, 2002

Schedule 20A

XVII. A. Staffing and Salary Costs
Line 32 - Other Health Care

Title	Hours Worked	Hours Paid	Salaries	Average Hourly Wage
Care Plan Coordinator	645	649	10,003	15.41
Ancillary Clerk	397	418	2,900	6.94
Total	1,042	1,067	12,903	12.09

See Accountants' Compilation Report

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carrell Breeze	Administrator	0%	$ 39,833
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 39,833

B. Administrative - Other

Description	Amount
Developmental Services of Illinois, Inc. - Administrative Service Fees	$ 210,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 210,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/C Consulting	$ 719
Lawrence A. Manson	Legal	147
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 866

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,365
Unemployment Compensation Insurance	7,815
FICA Taxes	63,981
Employee Health Insurance	29,587
Employee Meals	11,049
Illinois Municipal Retirement Fund (IMRF)*	
Employee Morale	3,385
TOTAL (agree to Schedule V, line 22, col.8)	$ 159,182

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	546
Health Care Worker Background Check	546
(Indicate # of checks performed 78)	
IHCA Dues	3,768
MES Dues	102
Miscellaneous Dues and Licenses	757
Parent company allocation	(11)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,908

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,589
Seminar Expense	2,301
Parent company allocation	(66)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,824

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Mount Vernon Care Center
Provider #: 0039826
07/01/01 to 06/30/02

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)			866
Allocated from Caravilla Charitable Corporation:			
	Altschuler, Melvoin & Glasser LLP	Accounting	6,057
	American Express Tax & Business Services	Accounting	1,799
Allocated from Caravilla Residential Centers, Inc.:			
	Altschuler, Melvoin & Glasser LLP	Accounting	9,100
	American Express Tax & Business Services	Accounting	411
	Lawrence Manson	Legal	2,555
	Crain, Miller & Associates	Legal	349
	Carr Korein Tillery	Legal	228
Allocated from Parent Company			
	Altschuler, Melvoin & Glasser LLP	Accounting	1,596
	American Express Tax & Business Services	Accounting	1,551
	Heinold-Banwart	Accounting	2,712
	Lawrence Manson	Legal	3,560
Total (agree to Schedule V, line 19, column 8)			30,784

See Accountants' Compilation Report

Center for Residential Management, Inc.
Professional Fees Allocation
June 30, 2002

American Express Tax & Business Services	Accounting	13,626
Altschuler, Melvoin & Glasser LLP	Accounting	14,178
Heinold-Banwart	Accounting	24,092
Lawrence Manson	Legal	31,620
Amount allocated through CRM allocation		83,516

Detailed legal invoice listing

Lawrence Manson	3,260
Lawrence Manson	4,360
Lawrence Manson	1,300
Lawrence Manson	5,600
Lawrence Manson	360
Lawrence Manson	3,420
Lawrence Manson	500
Lawrence Manson	2,540
Lawrence Manson	1,980
Lawrence Manson	2,720
Lawrence Manson	1,700
Lawrence Manson	3,880
	31,620

	Lakeview	Countryview	Sparta	Ellner	Taylorville	Gateway	Aviston	Briarbrook	Harris	Joshua	Terra	Park Place	Perrine	Okawville	WGarden	Galaxy	Cardinal	BGHill	Troy	CCH 185th	CCH Lee St.	Mt. Vernon	Jeffersonian	Casey	TOTAL
bed days available	52,925	-	5,840	5,840	5,840	-	5,840	5,840	5,840	5,840	5,840	5,840	1,460	2,190	1,460	2,920	-	2,920	1,460	2,190	1,638	23,360	23,725	38,690	207,498
Alloc. Percentage	0.255063	0.000000	0.028145	0.028145	0.028145	0.000000	0.028145	0.028145	0.028145	0.028145	0.028145	0.028145	0.007036	0.010554	0.007036	0.014072	0.000000	0.014072	0.007036	0.010554	0.007894	0.112579	0.114338	0.186460	1.000000
American Express Tax & Business Services	3,512	-	387	387	387	-	387	387	387	387	387	387	83	128	80	176	-	176	80	128	92	1,551	1,575	2,568	13,626
Altschuler, Melvoin & Glasser LLP	3,616	-	399	399	399	-	399	399	399	399	399	399	100	150	100	200	-	200	100	150	112	1,596	1,621	2,644	14,178
Heinold-Banwart	6,145	-	678	678	678	-	678	678	678	678	678	678	170	254	170	339	-	339	170	254	190	2,712	2,755	4,492	24,092
Lawrence Manson	8,065	-	890	890	890	-	890	890	890	890	890	890	222	334	222	445	-	445	222	334	250	3,560	3,615	5,896	31,620
	21,339	-	2,354	2,354	2,354	-	2,354	2,354	2,354	2,354	2,354	2,354	575	865	572	1,159	-	1,159	572	865	643	9,419	9,566	15,599	83,516

See Accountants' Compilation Report

Caravilla Residential Centers, Inc.
Legal Fees Allocation
June 30, 2002

Professional Fees:

Lawrence Manson	9,380
Crain, Miller & Associates	1,280
Carr Korein Tillery	838
	11,498

Detailed legal invoice listing:

Lawrence Manson	1,240
Lawrence Manson	1,320
Lawrence Manson	2,280
Lawrence Manson	180
Lawrence Manson	1,880
Lawrence Manson	1,140
Lawrence Manson	240
Lawrence Manson	1,100
Crain, Miller & Associates	1,120
Crain, Miller & Associates	160
Carr Korein Tillery	500
Carr Korein Tillery	338
	11,498

	Mt. Vernon	Jeffersonian	Casey Care	Total
number of beds	64	65	106	235
allocation %	0.27	0.28	0.45	1
Lawrence Manson	2,555	2,594	4,231	9,380
Crain, Miller & Associates	349	354	577	1,280
Carr Korein Tillery	228	232	378	838
	-	-	-	-
	3,131	3,180	5,186	11,498

See Accountants' Compilation Report

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $3,768**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **514** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **35,040**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,049** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **22%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin and Glasser LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit is currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Mount Vernon Care Cen** **03:43 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	101,467	equal to	101,467	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	174,418	equal to	174,418	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	70,647	equal to	70,647	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	2,966	equal to	2,966	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	367	equal to	367	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	1,777	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	335,055	equal to	335,055	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	631,128	equal to	631,128	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	405,948	equal to	405,948	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	269,485	equal to	269,485	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	9,800	equal to	9,800	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	35,040	equal to	35,040	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	518,411	equal to	553,777	-35,366	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	25,074	equal to	25,074	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	17,743	equal to	17,743	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	75,373	equal to	75,373	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	18,402	equal to	18,402	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	53,595	equal to	53,595	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	35,012	equal to	35,012	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	39,833	equal to	39,833	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	18,501	equal to	18,501	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	837,310	equal to	837,310	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	3,881	< or = to	3,881	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	741	< or = to	741	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	922	< or = to	1,306	-384	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	922	< or = to	922	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	39,833	equal to	39,833	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	210,300	equal to	210,300	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	866	equal to	866	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	159,182	equal to	159,182	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	5,908	equal to	5,908	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	3,824	equal to	3,824	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	35,040	equal to	35,040	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	11,049	< or = to	54,279	-43,230	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	11,049	equal to	11,049	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	114,599	equal to	114,599	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	1,958,520	equal to	1,958,520	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	N/A	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	60,000	equal to	60,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,441,509	equal to	1,441,509	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	245,603	equal to	245,603	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	456,585	equal to	456,585	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	41,032	equal to	41,032	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-63,459	equal to	-63,459	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	664,892	equal to	664,892	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	75,373	7,691	3,881	86,945	0	86,945	0	86,945
2. Food P	0	78,270	0	78,270	0	78,270	-11,049	67,221
3. Housek	53,595	5,671	0	59,266	0	59,266	0	59,266
4. Laundry	35,012	6,987	0	41,999	0	41,999	0	41,999
5. Heat ar	0	0	35,433	35,433	0	35,433	0	35,433
6. Mainter	18,402	0	14,740	33,142	0	33,142	0	33,142
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	182,382	98,619	54,054	335,055	0	335,055	-11,049	324,006
9. Medical	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursin	553,777	22,977	741	577,495	0	577,495	0	577,495
10a. Thera	0	0	367	367	0	367	0	367
11. Activiti	25,074	1,780	1,306	28,160	0	28,160	0	28,160
12. Social	17,743	38	922	18,703	0	18,703	0	18,703
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	403	403	0	403	0	403
15. Other	0	0	0	0	0	0	0	0
16. Total H	596,594	24,795	9,739	631,128	0	631,128	0	631,128
17. Admin	39,833	0	210,300	250,133	0	250,133	0	250,133
18. Direct	0	0	0	0	0	0	9,151	9,151
19. Profes	0	0	866	866	0	866	29,918	30,784
20. Fees,	0	0	5,844	5,844	0	5,844	64	5,908
21. Clerica	18,501	4,134	18,576	41,211	0	41,211	-1,583	39,628
22. Emplo	0	0	104,903	104,903	0	104,903	54,279	159,182
23. Inserv	0	0	22	22	0	22	0	22
24. Travel	0	0	2,562	2,562	0	2,562	1,262	3,824
25. Other	0	0	407	407	0	407	1,012	1,419
26. Insura	0	0	0	0	0	0	38,109	38,109
27. Other	0	0	0	0	0	0	0	0
28. Total (	58,334	4,134	343,480	405,948	0	405,948	132,212	538,160
29. Total (	837,310	127,548	407,273	1,372,131	0	1,372,131	121,163	1,493,294
30. Depre	0	0	6,514	6,514	0	6,514	64,133	70,647
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	3,502	3,502	0	3,502	170,916	174,418
33. Real E	0	0	0	0	0	0	0	0
34. Rent -	0	0	256,545	256,545	0	256,545	-256,545	0
35. Rent -	0	0	2,924	2,924	0	2,924	42	2,966
36. Other	0	0	0	0	0	0	9,773	9,773
37. Total (	0	0	269,485	269,485	0	269,485	-11,681	257,804
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	0	0	0	0	0	1,777	1,777
40. Barber	0	0	8	8	0	8	0	8
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	35,040	35,040	0	35,040	0	35,040
43. Other	0	0	9,792	9,792	0	9,792	-9,792	0
44. Total S	0	0	44,840	44,840	0	44,840	-8,015	36,825
45. Grand	837,310	127,548	721,598	1,686,456	0	1,686,456	101,467	1,787,923

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	89,965	89,965
2. Cash - F	0	0
3. Account	223,074	223,074
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	5,479	5,479
7. Other Pr	192	192
8. Account	319,229	319,229
9. Other (s	1,376	1,376
10. Total c	639,315	639,315
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	0	60,000
14. Buildin	0	1,234,994
15. Leaseh	6,276	206,515
16. Equipn	34,773	245,603
17. Accum	-16,972	-456,585
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other l	0	0
23. other (s	1,500	1,500
24. Total L	25,577	1,292,027
25. Total A	664,892	1,931,342
CURRENT LIABILITIES		
26. Accour	97,134	97,134
27. Officer'	0	0
28. Accour	0	0
29. Short-T	6,536	6,536
30. Accrue	50,347	50,347
31. Accrue	0	0
32. Accrue	0	0
33. Accrue	0	0
34. Deferre	0	0
35. Federa	0	0
36. Other C	465,802	113,053
37. Other C	0	0
38. Total C	619,819	267,070
LONG TERM LIABILITES		
39.Long-Te	4,041	1,951,984
40.Mortgag	0	0
41.Bonds I	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	4,041	1,951,984
46.Total Li	623,860	2,219,054
47.Total Eq	41,032	-287,712
48.Total Li	664,892	1,931,342

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,615,084
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	1,615,084
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	678
7. Oxygen	0
Subtotal - Anciliary Revenue	678
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	450
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	2,745
22. Laundry	0
Subtotal - Other Operating Revenue	3,195
24. Contributions	0
25. Interest and Other Investments Income	81
Subtotal - Non-Operating Revenue	81
27. Other Revenue (specify):	3,959
28. Other Revenue (specify):	0
Subtotal - Other Revenue	3,959
30. Total Revenue	1,622,997
31. General Services	680,120
32. Health Care	1,154,988
33. General Administration	668,561
34. Ownership	144,710
35. Special Cost Centers	60,174
35. Provider Participation Fee	41,063
37. Other	0
40. Total Expenses	2,749,616
41. Income Before Income Taxes	-1,126,619
42. Income Taxes	0
43. Net Income or Loss for the Year	-1,126,619

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Line 16 for mortgage insurance.